

CONFIDENTIAL



PATIENT CASE HISTORY

PERSONAL INFORMATION:

Name _____ Today's Date _____
Address _____ City _____ State _____ Zip _____
Preferred Phone Number (H,C,W) _____ Alt Phone (H,C,W) _____
Age _____ Birthday _____ Gender: F M # Children _____ Marital Status: M S W D
Employer _____ Occupation _____
Emergency Contact (Parent if Pt is a minor) _____ Phone _____
Referred by _____

HEALTH INFORMATION:

Reason for today's visit _____

When did this condition start? _____ How did this condition begin? _____

Have you had this or similar conditions previously? _____

What percent of the day do you experience this condition? _____

Is this condition changing? Getting better _____ Getting Worse _____ Not Changing _____

How severe is this condition at its: a. worst: None 1 2 3 4 5 6 7 8 9 10 Unbearable

b. best: None 1 2 3 4 5 6 7 8 9 10 Unbearable

What makes your condition feel worse? _____

What makes your condition feel better? _____

How does this condition affect your daily life? _____

What treatment have you received for this condition? _____

Have you been to a chiropractor before? Who? When? _____

Name and location of family physician _____

Have you had any x-rays taken in the last 12 months? Where? _____

List surgical operations/serious illnesses and years _____

Have you been in an auto accident? Past year Past 5 years Over 5 years Never

Describe: _____

Have you had any other personal injury or accident? Past year Past 5 years Over 5 years

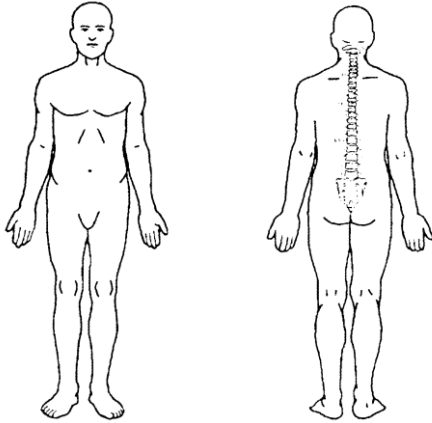
Describe: _____

Medications (prescription and over-the-counter), nutritional/herbal supplements you currently take _____

What do you expect from your visit/treatment today? _____



Please mark your areas of pain on the figures below.



Past Present

- Headaches
- Neck Pain
- Upper back pain
- Mid Back Pain
- Low Back Pain

- Shoulder Pain
- Elbow/Arm Pain
- Wrist/Hand Pain
- Hip/Upper Leg Pain
- Knee/Lower Leg Pain

- Jaw Pain
- Joint Swelling/Stiffness/Arthritis
- General Fatigue
- Neurological Condition
- Visual Disturbances
- Dizziness

Past Present

- Skin Issues
- Eye/ear/nose/throat Problems
- Respiratory Condition
- Heart Condition
- Chest Pain
- Blood Disorder
- Abdominal Pain

- Ulcer
- Liver/Gallbladder Problems
- Digestion Issues
- Bowel/Bladder Issues
- Menstrual Irregularity
- Prostate Problems

Past Present

- Abnormal Weight Gain/Loss
- Allergies
- Autoimmune Disease
- Cancer
- Chronic Sinusitis
- Depression
- Diabetes

- Hepatitis
- High Blood Pressure
- HIV/AIDS
- Loss of Appetite
- Stroke
- Tumor

Please list if any immediate family members have/had any of the previous _____

Signature of Patient or Responsible Party

Date

Relationship to Patient

Patient Name _____



PAYMENT INFORMATION:

I understand that it is my responsibility to know my insurance benefits for chiropractic care. I agree to pay for all services and/or supplies provided to me during the course of my treatment and that if, for any reason, St Croix Chiropractic and Wellness does not receive payment from my insurance carrier I agree to pay for any balances due in a timely manner. Any treatment will be discussed with me, and I will be able to make the final decision regarding the rendering of such care and/or treatment.

I hereby assign to St Croix Chiropractic and Wellness all insurance and or Medicare benefits and payments to which I am entitled in conjunction with my chiropractic treatment. This assignment is ongoing and continuous for the duration of my treatment unless canceled by me in writing to the insurer(s) with a copy to St Croix Chiropractic and Wellness. If a claim for worker's compensation benefits has been filed by my employer and approved by the insurance carrier, and in the event worker's compensation denies my claim, I will assume financial responsibility for all charges.

RELEASE OF MEDICAL INFORMATION:

I authorize the release of all health information in my record that is relevant to any insurance company or public agency which may be involved with my care for the purpose of determining benefits. I authorize St Croix Chiropractic and Wellness to review my medical history and insurance information for the purpose of providing chiropractic care. I understand that this authorization is in effect for the duration of my treatment and or until all outstanding sums relating to this treatment are satisfied or until I choose to revoke it in writing to: St. Croix Chiropractic and Wellness, P.O Box 883 St Croix Falls, WI 54024

INFORMATION ABOUT POSSIBLE RISKS OF TREATMENT:

You have the right, as a patient, to be informed about your condition and the recommended integrative and complementary procedure to be used so that you make an informed decision whether or not to undergo the procedure after knowing the risks and hazard involved. This disclosure is not meant to scare or alarm you; it is required by law, and is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

Doctors of Chiropractic, Medical Doctors, and Physical Therapists using manual therapy treatments for patients with headache and cervical spine (neck) complaints, are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The chances of this happening are estimated to be approximately from 1 per 400,000 treatments to 1 per 10 million treatments. Appropriate tests will be performed to help identify if you may be susceptible to this type of injury; you will be notified if that is the case. If you have any questions about this, please do not hesitate to speak with your practitioner.

As with any health procedure, complications may arise during treatment. These complications include soreness, muscle or ligament strain, dislocations, fractures, disk injuries, physiotherapy burns. These are extremely rare occurrences.

CONSENT FOR TREATMENT:

I authorize Dr. Joy K. Zasadny, DC, to perform an examination, diagnostic testing and treatment as deemed necessary. I certify that no guarantee or assurance has been made to the results that may be obtained. I certify that the information I have provided is correct to the best of my knowledge, and I will not hold Dr. Joy responsible for any errors or omissions that may have been made in the completion of this form. Having carefully read the above, I hereby give my informed consent to have chiropractic care administered.

I have been informed of the HIPAA patient privacy information _____ (initial here)

If you have any questions regarding this form or the above statements, please ask Dr. Joy.

Signature of Patient or Responsible Party

Date

Relationship to Patient

Patient Name _____